Each facility reported a different array of service or staffing changes needed to meet the OBRA mandates. In addition, some of the freestanding ICF-IIs submitted cost estimates for items that were not OBRA-mandated nor included in the February 2, 1989 Requirements for Participation. Some of those costs, however, were deemed to be for services or staffing increases related to the intent of the OBRA legislation--that of providing quality services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of the residents. For that reason, some of those costs were allowed in the OBRA rate adjustment. The following is a summary of the items submitted that were determined to be related to the OBRA mandates:

- Infection control committee: hours for persons not on facility salary (physician, dietician), materials, equipment
- Additional housekeeping time (labor, benefits, education)
- Increased laundry staff time and space
- Quality assurance committee: hours for persons not on facility salary (physician, dietician, pharmacist), materials, equipment
- Medical director
- Consultant dietician
- Consultant pharmacist
- Additional staff time/postage for scheduling physician visits
- Resident fund accounting
- Additional time for resident assessments
- Staff development for new nursing assistant in-services, speakers, materials, additional RN trainer time, miscellaneous expenses
- NA training and competency evaluation program for new hires
- Staff time spent in training, in-services
- Increased social services
- Increased office and medical records time costs
- Increased activities programs
- Addition of a full-time director of nursing
- Advisory dentist
- Preadmission screening scheduling time
- Soiled utility room
- Cubicle curtains
- Call light systems
- Hand rails

The last four items on the list were included in the rate adjustment determinations as capital costs for the facility. The adjustment for those items was the amount of annual interest payment that the facility would be required to make on the cost of these items, paid over the 18-month period of the adjustment.

The former freestanding ICFs submitted other costs in their estimates that were not related to OBRA requirements or the February 2, 1989 Requirements for Participation. These tended to be requests for additional funding for services already included in the facility's per diem rates and were not included in determining the OBRA rate adjustments.

The cost estimates submitted by the freestanding ICF-IIs generally related to procedures utilized by the facility rather than the need for additional facility staff. For that reason, it was determined that the OBRA cost adjustment for freestanding ICF-II facilities should be based on the annual cost per bed of providing those services in that facility.

Analysis of facility cost report data and the costs submitted by the freestanding ICF-IIs was performed to determine how large an increase would be needed to meet the majority of these cost increases for the majority of freestanding ICF-IIs. The most recent available cost report data was from Report Year 1988 (October 1, 1987 to September 30, 1988). This data was adjusted for inflation. As shown below, the rate adjustment to the freestanding ICF-IIs provided, in the aggregate, a rate increase that covered 64 percent of the additional requested costs related to the OBRA mandates, which were not already covered in the nurse staffing adjustment.

OBRA 87 COST REQUESTS SUBMITTED BY FREESTANDING ICF-II FACILITIES

Total Increases Requested by ICF-IIs Eligible for the Adjustment	$400,869
Rate Adjustment Allowed	$257,691
Percentage Increase	64 percent

Additional adjustments for call light systems and hand rails were provided to freestanding ICF-II facilities that could not make these needed improvements within their current rate. This adjustment was effective October 1, 1990.

C. Analysis of the cost increases which were to be incurred by certified nursing homes (SNFs, ICF-Is, and attached ICF-IIs).

The state utilized the chart, which begins on page 25, to show the differences between the current licensure and certification requirements and the OBRA certification requirements in order to analyze the potential cost increases anticipated by the former SNFs, ICF-Is, and the attached ICF-IIs. Minnesota also considered input from provider groups.

A review of the chart indicates that there were practically no changes for SNFs and only a few changes for former ICF-Is. These few changes are discussed below. Worst-case cost estimates are provided, unless otherwise noted.

NURSE AIDE TRAINING AND COMPETENCY EVALUATION PROGRAMS
The State of Minnesota offered the competency evaluation to nurse aides employed in NFs by July 1, 1989 at no charge to the nurse aides or the facilities. The legislature appropriated $1.2 million as its share of Medicaid administrative costs to match federal dollars available for the initial nurse aide competency evaluation. Ninety-eight percent of the people required to complete the competency evaluation passed both the written and manual skills tests.

The major cost to the former SNFs, ICF-Is, and attached ICF-IIs was anticipated to be the additional hours required for nurse aide training program. Minnesota had required a 30-hour nurse aide training program and passing of a state-administered competency test upon completion of that training program. For many years before OBRA, nurse aide training and the competency test has been an allowable cost for Minnesota nursing facilities, reported on their annual cost report.

Historically, facilities had no standard way of handling the costs of the nurse aide training and testing. Some facilities used to provide the training themselves and utilized the state-administered competency test offered by the technical colleges. Some facilities used to have agreements with a local technical or community college to provide training to newly hired aides. Other facilities had

a policy of hiring only persons who had already completed their training and competency test. In addition, some scholarships and aid programs paid for nurse aide training for low income persons. To some degree, these patterns have continued.

Public Law 101-239 (OBRA 89) stated that nurse aides cannot be charged for the costs of the training program, materials or the competency evaluation. This meant that nursing facilities must pay these costs, or hire only persons who have already completed the training and competency evaluation. It is expected that more facilities will choose to hire only previously trained and tested nurse aides, as long as that group is sufficiently large enough to meet the demand in nursing facilities.

In order to estimate the increased costs to facilities for the nurse aide training and competency evaluation programs, some assumptions were made, based on the most recent available data. At the time of the January 1, 1990 rate adjustment, approximately 3,000 persons successfully completed the nurse aide test annually; this number was assumed to remain constant. The average cost for the old 30-hour training program and test was $110; the average cost of the 75-hour training program and competency evaluation program was expected to be $200. Multiplying $90 [$200 minus $110] times 3000 students, the expected annual additional cost for nurse aide training and competency evaluations was expected to be $270,000.

Information from HCFA has indicated that nurse aide training and competency evaluation costs will only be allowed as a Medicaid administrative cost. Minnesota has revised facility reporting procedures to separate all actual training and competency evaluation costs in order to claim them as administrative costs. While the State has included these costs on the provider's annual cost report and in the payment rate, the State accounts for these costs as administrative costs by adjusting Federal Financial Participation (FFP) for these costs to 50 percent on the HCFA-64 Quarterly Expenditure Report.

Additional dollars to cover nurse aide wages for those who were expected to be hired before completing the training and competency evaluation were also added to the rate adjustment analysis. The Minnesota Salary Survey of Hospitals and

Nursing Homes for 1989, compiled by the Minnesota Department of Jobs and Training, was the source for the statewide average nurse aide salary. Multiplying 3,000 new nurse aides per year by the additional 45 hours of training required (the test was already required, so those hours were not new costs), then multiplying that number by $6.35 (the statewide average nurse aide salary rate for 1989, plus 5 percent inflation), and adjusting the total upwards by 40 percent for fringe benefits, Social Security taxes, and other employer costs, produced an estimated annual cost to nursing facilities of $1,200,150 for nurse aide wages for the training and competency evaluation. While a number of nurse aides are hired after training paid for through scholarships, this estimate was not reduced to reflect those reduced costs.

SOCIAL SERVICES

OBRA required NFs to staff a full-time social worker if the facility has 120 or more beds. Cost report data submitted by nursing facilities indicated that only 13 facilities with 120 or more beds did not already have a full-time social worker on staff. Some of those 13 facilities reported almost the equivalent of a full-time social worker, while several reported part-time social workers. The 13 facilities together reported a shortage of 10,592 social worker hours. The Minnesota Salary Survey of Hospitals and Nursing Homes for 1989, prepared by the Minnesota Department of Jobs and Training was the source for the statewide average salary for social workers. The statewide salary at the 75th percentile, adjusted for inflation and increased by 30 percent to account for fringe benefits and payroll taxes, equaled $14.82 per hour. Therefore, the total annual estimated cost to cover the increased social worker hours was $157,000.

MEDICAL DIRECTOR

Former ICFs were not previously required to have a medical director, although it has been a common practice. Some facilities did not have to change at all, others needed to increase their medical director's contracted hours, while a few needed to retain the services of a medical director. Using data from facility cost reports for Report Year 1988, the average cost reported for a medical director by ICFs was $4,100 per facility (total reported costs of $286,783 divided by the 70 reporting facilities). There were 84 former ICF-Is and ICF-IIs that did not report having a medical director. Costs to meet this requirement varied among nursing

facilities based on the number of beds in each facility, but using our worst-case estimates, the total anticipated cost to implement this requirement was estimated at $344,400.

RESIDENT ASSESSMENTS

In September 1990, HCFA designated a resident assessment system that included a form containing the Minimum Data Set (MDS), utilization guidelines, and resident assessment protocols. Minnesota has designated the HCFA resident assessment instrument containing the MDS for NF use. Nursing facilities are required to use the MDS to conduct an assessment upon admission and periodically thereafter on every resident in their facility. NFs were already required to complete resident assessments upon admission, and to review those assessments quarterly as part of the resident care planning process. Assessments are also required within five days of return from the hospital and again 30 days thereafter to capture major changes in resident condition.

The State anticipated increased costs to facilities to complete this additional form, once HCFA issued the final requirements. Estimates from Research Triangle Institute and state survey agencies that tested the form, indicated that the average time to complete the MDS is one hour, or an increase of 20 minutes over the facility assessments required by the former regulations. OBRA regulations required a registered nurse to complete the resident assessment. There are about 42,700 residents in NF-Is in Minnesota. The statewide average hourly cost of registered nurse services (wages plus benefits and related costs) is $18.00. Assuming a 20-minute increase in time, at $18 per hour, each assessment could cost an additional $6.00. The total additional resident assessment costs were estimated at $256,200 for each required assessment, or up to $1,024,800 annually if the assessment were conducted four times per year.

PHARMACY CONSULTANT

A new OBRA requirement was each resident's independent monthly drug regimen review. The monthly review averages five minutes per resident. Some facilities were already conducting this drug regimen review, and so there are some costs already built into their rate base for this activity. We assumed, however, that all costs were new. At a pharmacist contract rate of $20 per hour times approximately

42,700 NF-I residents, this cost was estimated at $20 per resident per year, or a statewide total of $854,000.

RESIDENT FUND ACCOUNTING
Before the OBRA mandates, NFs in Minnesota could choose not to hold residents' funds. Most facilities, however, did accept resident funds. The new provisions stated that facilities must accept resident funds if the resident requests that of the facility. Costs for providing this service varied between nursing facilities, but most facilities were expected to have no additional costs for implementing this provision.

INFECTION CONTROL COMMITTEE
Former ICFs were required to have infection control procedures, although they did not necessarily have an infection control committee. The new requirements stated that all NFs must have an infection control committee, which many facilities had already established. A few facilities have required some staff time to establish a committee. Costs to meet this requirement were expected to vary between nursing facilities.

SUMMARY
Most facilities routinely provided services far and above what was required under former certification regulations. Many individual practice variables are involved in facility management decisions, which have affected facility cost patterns. It was impractical to take into account every individual facility practice variation in the calculation of rate adjustments. We have attempted to account for the major differences on a facility-specific basis. The remaining anticipated estimated costs were averaged out over all nursing facilities to calculate an average per diem increase.

DEMONSTRATION OF HOW THE ESTIMATES OF THE ADDITIONAL COSTS INCURRED BY NURSING FACILITIES IN COMPLYING WITH THE NEW REQUIREMENTS ARE ACCOUNTED FOR IN THE PROPOSED PAYMENT RATES.

After research, analysis, and public input, the State determined there would be three portions to the OBRA rate adjustment. One portion of the adjustment related to the increase in licensed and registered nursing hours for what were formerly known as the ICF-Is and freestanding ICF-IIs. The second portion of the adjustment took into account the need to provide additional

remuneration for the freestanding NF-IIs to bring them into compliance with NF requirements. The third portion of the adjustment provided an increase in the daily rate for nursing homes (NF-Is and attached NF-IIs) in order to cover the additional requirements that are a direct result of OBRA mandates that expand on current state and/or federal requirements.

Minnesota has a prospective payment system, and payment rates are calculated based on historical costs reported by facilities. There is a delay between the actual expenditures and the inclusion of those expenditures in payment rates. Because of this rate-setting method, it was preferable to provide up-front rate adjustments for the increased costs of meeting the OBRA 87 requirements in order to lessen the financial impact of these changes on providers.

The three adjustments were included in the facility rates, beginning in January 1990, nine months in advance of the requirements. This was done in order to provide the facilities with the up-front funds to hire staff and provide additional services in order to meet the new requirements by the time the requirements went into effect.

The adjustments were in effect for 18 months, until June 30, 1992. The payment of the adjustments in advance also allowed the inclusion of increased costs in the cost base for the reporting year beginning October 1, 1990 and ending September 30, 1991. The costs in the September 30, 1991 cost report were reflected in the July 1, 1992 rates, which were effective immediately after the expiration of the one-time OBRA rate adjustments on June 30, 1992. Additional facility costs that can be included in per diem rates are allowable up to the established limits.

A. Adjustment for nurse staffing coverage for former freestanding ICF-Is and freestanding ICF-IIs).

This adjustment allows an incremental rate increase designed to bring former ICFs up to 24 hours per day licensed nursing coverage, eight hours per day, seven days per week registered nursing coverage. The adjustment amount was based on historical reported costs for individual nursing facilities. Former SNFs and SNF/ICF combinations already provided this level of nursing coverage. Consequently, this adjustment was available only to former freestanding ICFs, a total of 51 facilities.

The method used to determine the nursing coverage adjustment each NF received was to calculate the incremental cost necessary to upgrade the nursing staff coverage to the new OBRA requirements. For example, if a facility already staffed an RN five days per week, eight hours per day, the facility was eligible for a rate increase for additional RN coverage for two days per week, eight hours per day. If a facility staffed licensed nursing coverage for 16 hours per day, it was then be eligible for a rate increase for additional LPN coverage of eight hours per day. Facilities were provided an increase in the amount equal to the difference between reported nursing assistant wages and reported licensed nursing wages to cover the increase to 24-hour licensed nursing coverage.

The increased cost of professional nursing for an eligible nursing facility was determined by applying the following formula:

(1) Subtract from the number 8760 (24 hours per day, seven days per week) the compensated hours for professional nurses, both employed and contracted, and, if the result is greater than zero, multiply the result by $4.55;

(2) Subtract from the number 2920 (eight hours per day, seven days per week) the compensated hours for registered nurses, both employed and contracted, and, if the result is greater than zero, then multiply the result by $9.30;

(3) If a NF has fewer than 61 licensed beds, the director of nurses' compensated hours must be included in the compensated hours for professional nurses in clause (1). If the director of nurses is also a registered nurse, the director of nurses' hours must be included in the compensated hours for registered nurses in clause (2); and

(4) The one-time nursing staff adjustment to the payment rate was the sum of clauses (1) and (2), as adjusted by clause (3), if appropriate, and then divided by the nursing facility's actual resident days for the reporting year ending September 30, 1988.

Clause (3) was based on the State's formula for computing this data for state licensure standards. In order to be consistent with State statutes and with certification provisions, it was

necessary to include that clause in the formula for determining the nurse staffing coverage increase.

If a nursing facility was granted a waiver to the minimum professional nursing staff standards under P.L. 100-203 for either the professional nurse adjustment referred to in (1) above, or the registered nurse adjustment in (2), the State agency recovers the portion of the nursing facility's payment rate that relates to a one-time nursing staff adjustment granted under this section. The amount to be recovered is based on the type and extent of the waiver granted.

B. Adjustment for freestanding boarding care homes (NF-IIs).

In addition to the adjustment covering the increased costs of providing the nursing coverage mandated by OBRA 87, the freestanding NF-IIs received an additional rate adjustment. This adjustment covered increased costs for a medical director, nursing assistant training for newly hired nursing assistants, ongoing in-service training for nursing assistants, and other requirements mandated by OBRA.

Since these facilities were the least likely to meet OBRA requirements prior to January 1, 1990, they were asked to detail their individual estimated costs to comply with those requirements. The State determined which costs were reasonable and necessary to operate an efficient and economical freestanding NF-II in compliance with OBRA requirements. All costs, except those associated with the licensed nurse staffing increase, were included in the calculation of the adjustment, as long as they were within the legislative limit of $300 per bed per year. (The nursing coverage costs were included in a separate adjustment described above.) In addition, some costs not directly due to OBRA 87 mandates, but which enhanced facilities' ability to attain or maintain the highest practicable physical, mental and psychosocial well-being for each resident were allowed in the calculation of the adjustment for the freestanding NF-II facilities.

Twenty-one freestanding NF-IIs were identified as eligible for this adjustment. These facilities were contacted by letter and by telephone to request a detailed estimate of their costs to come into compliance with the new OBRA requirements. Nineteen facilities submitted estimates of their increased costs; the other two facilities were repeatedly contacted for